GRIEVANCE ACKNOWLEDGEMENT LETTER

[Date]

[Member's Name]
[Address]
[City, State, Zip]

HWLA Member Identification #: *[insert number]*
DMH IS #: *[insert number]*

Dear [Member]:

We received your grievance on *[insert date]*. Thank you for letting us know about your concern.

We will investigate your grievance and will contact you if we need more information. We will mail you our decision within 60 days.

We value you as a DMH Healthy Way LA (HWLA) member and we will make every effort to meet your mental healthcare needs.

If you change your mind about wanting us to look into your grievance, please let us know.

If you have any questions or concerns, please contact [insert name], DMH Patients' Rights Advocate at (213) 738-4949.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

_____
(Name of Patients' Rights Advocate)

c: Requesting Provider/Clinic/CAU